HOMECARE

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TESTIMONY

BEFORE THE COMMITTEE ON COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

U.S. HOUSE OF REPRESENTATIVES

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ON BEHALF OF THE

NATIONAL ASSOCIATION FOR HOME CARE

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Mr. Chairman,

Thank you for the opportunity to present testimony today on issues related to the Medicare home care benefit. My name is Margaret J. Cushman. I am the President of VNA Health Care in Hartford-Waterbury, Connecticut. I also chair the Government Affairs Committee of the National Association for Home Care (NAHC), as well as serve on the NAHC Prospective Payment System (PPS) Task' Force.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies, like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

The National Association for Home Care thanks you, Mr. Chairman, and Members of the Committee, fr the support you have expressed for PPS for home care, as well as your leadership in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from Part A to Part B of Medicare.

NAHC is deeply appreciative of the support and attention PPS for home care has received from this Committee and in this Congress. We have been advocating such a system for more than a decade. Congress, too, has been pushing the Administration for development of a PPS for home care for many years. We were very pleased that proposals to implement such a system were included in the balanced budget plans offered in the last Congress by both parties, and that a PPS plan was passed by the full Congress as a part of HR2491, the Seven Year Balanced Budget Act (BBA) in lieu of copays. We also deeply appreciate the introduction of the industry's Revised Unified PPS plan, HR4229, by Representative Nancy Johnson.

I'd like to ask permission, Mr. Chairman, to have my full written statement, along with the following attachments, included in the hearing record:

- a detailed description of the industry's Revised Unified Plan,
- a chart showing the characteristics of Medicare home care patients,
- detailed comments on the President's FY98 budget proposal, and
- a copy of a letter from home health and hospice associations in all 50 states opposing transferring home care coverage from Part A to Part B of Medicare.

My testimony is organized as follows:

- factors affecting growth in home care,
- concerns about and efforts to address fraud and abuse,
- discussion of PPS. and

- discussionof the President's FY98 budget proposals and other proposals that affect home care.

I. FACTORS AFFECTING GROWTH IN HOME CARE

Home care encompasses a broad spectrum of both health and social services that can be delivered to recovering, disabled or chronically ill persons in their homes. These services include the traditional core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, and medical social services.

Generally home care is appropriate whenever a person needs health care assistance that cannot be easily or effectively provided solely by a family member or friend on an ongoing basis for a short or long period of time. There are many situations and conditions for which home care services are especially appropriate. Technology advancements mean that every day more people are able to be cared for effectively and efficiently at home even if they have illnesses that, at one time, were only treatable in hospitals or institutions.

The home health benefit has been an evolving benefit for most, if not all, of its existence in the Medicare program. In Medicare's earliest years, home health expenditures amounted to only about 1% of the total. Today, approximately 9 % of total Medicare payments are made for home health services. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1996, nearly 4 million Americans received Medicare home health services, representing an estimated $18 billion in Medicare spending. Much of the increase over time can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services.

Home health growth, however, is expected to moderate and fall to more modest levels in the next few years. The HCFA Office of the Actuary expects annual growth in the volume of visits to steadily decrease to around 6% through the year 2000.

Reductions in Hospital Lengths of Stay Growth in the home health benefit must not be looked at in isolation. There is a direct connection between the effect of PPS on hospitals and the growth in the home care benefit. PPS has made it in the hospitals' best interest to move patients out of hospitals as soon as possible, and to collect the full DRG payment for fewer days of care. In fact, over the last six years, lengths of stays in hospitals fell 3 1% in the DRGs most associated with post-acute care use. Average costs per discharge also declined about 6% during the same time period.

Despite a decade of continual reductions in the hospital lengths of stay, the Medicare hospital updates have never reflected these changes. Decreases in the hospital lengths of stay should be reflected in Medicare payments to hospitals. In the President's FY98 budget, home health and other post-acute care providers are penalized for the growth in their areas that have been fueled by hospitals. Hospital

payment rates should be reduced to reflect this change, rather than hitting home care and other post-acute care providers.

Several other factors explain the growth in home health benefit not associated with quicker discharges of more acutely ill patients from hospitals.

Coverage Clarification In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be covered. The result was a "chilling effect" in which some Medicare covered claims were diverted to Medicaid and some patients went without care. This "denials crisis" led in 1987 to a lawsuit (*Duggan* v. *Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrariness had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25%) came in 1989 when the clarifications were announced; and an even larger increase took place (50%) in 1990, the first full year the new policies were in effect.

Cost Effectiveness Home health has moved well beyond its traditional boundaries, making it possible for patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment. It is also important to note that while growth in home care has been experienced in the number of visits provided per patient, home care's costs have remained steady over the last decade, making home care still one of the best health care buys.

An Aging Population The aging of the U.S. population will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85 are three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 9,923 in 1996. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference The past decade has seen dramatic increases in awareness among

physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38 % of Americans knew about home care; by 1988, over 90% of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A 1992 poll found that the American public supports home care by a margin of nine to one over institutional care. Nearly 82% of all accredited medical schools now offer home health care training in their curricula.

Technological Advances Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Reductions in home care spending are likely to result in greater Medicare expenditures for hospital inpatient and emergency care, physician services, and nursing home care. Home health care serves as the safety net for patients who are discharged from acute and rehabilitation hospitals after shorter lengths of stay.

II. CONCERNS ABOUT AND EFFORTS TO ADDRESS FRAUD AND ABUSE

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved -- patients, payors, and providers -- to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

NAHC has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In January 1994, NAHC implemented a broad new policy governing member conduct. While America has enhanced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and must be eliminated.

The principles of NAHC's policy are as follows:

1. POLICY ON MEMBER SELF-REGULATION

Where a NAHC member, agency, individual member, or an applicant for membership has been determined or is controlled by an individual who has been determined to have violated a criminal or

civil law in either Federal or State Court on issues related to fraud and abuse, the NAHC Board of Directors may consider the imposition of sanctions, including the termination or rejection of NAHC membership.

2. **POLICY ON PUBLIC RELATIONS**

NAHC shall respond proactively and reactively to any public relations crisis concerning fraud and abuse activity in home care and hospice.

3. POLICY ON EDUCATION OF MEMBERS

Consistent with its mission and commitment to provide educational opportunities for members, and for the purposes of promoting standards of quality and ethics in the delivery of home care and hospice services, NAHC will provide education regarding issues of fraud and abuse in home care and hospice.

4. POLICY ON ENFORCEMENT

It is the responsibility of any NAHC staff person or any NAHC member to report to the appropriate legal authority any violation of fraud and abuse laws. No report shall be made by NAHC staff except where sufficient information has been obtained which demonstrates that there is a substantial likelihood that the law has been violated. Witnessing or having knowledge of an crime and not reporting it would constitute unethical behavior.

When government enforcement officials fail to act to address flagrant violation of the fraud and abuse law, NAHC may bring a civil enforcement action against the unscrupulous provider where authorized by a super majority of the Board of Directors.

5. POLICY ON SUPPORTING FRAUD AND ABUSE LEGISLATION

NAHC shall actively support and/or initiate legislative and regulatory measures appropriate to prevent or combat fraud and abuse in the home care and hospice industries.

6. POLICY ON REQUEST FOR ASSISTANCE

NAHC's assistance to member agencies under investigation for health care fraud and abuse shall be available only when it is determined that it is the best interests of the home care and hospice industry at large.

This policy is the embodiment of the NAHC efforts since its inception in 1983. Its enactment in 1994 was an affirmation of NAHC's commitment to maintain a leadership role in this troubling area. Evidence of NAHC's commitment is most evident in support of legislative efforts to control fraud. In 1993 and 1994, and continuing today, NAHC has publicly supported and worked to advance legislation which would expand existing health care fraud laws under Medicare and Medicaid to all payors in health care. This expansion would work to eliminate activities which escape scrutiny

because of the lack of controls in certain states which allow for conduct with private health insurance payments that would be illegal if federal payments were involved. NAHC has also aggressively supported the creation of a private right of action under federal anti-kickback laws to supplement the limited resources of government enforcement agencies. In this same respect, NAHC has repeatedly supported increased funding for the Office of Inspector General at HHS.

Legislation is also needed to control the quality and delivery of home infusion therapy services. This $3 billion segment of the home care industry operates under virtually no regulatory controls and presents an environment for improper, but not necessarily illegal, conduct to occur. In 1994, NAHC highlighted the need for controlling legislation such as that offered by Congressman Sherrod Brown in the so-called "Sara Weber" bill.

Fraud has also existed within the Medicaid programs. The states' Medicaid anti-fraud units have proven success in attacking this area. NAHC has and continues to support the continuation of these programs.

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of the standards of conduct that are allowable. Internal self-audit and self-enforcement must be done to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to extend this education to the greatest degree possible.

NAHC believes that increased public awareness is a valuable means of oversight and that the public must be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concern.

One of the most important roles that the home care industry plays in eliminating fraud and abuse is to lend its knowledge and expertise to enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels, NAHC has put individuals and providers of services who have evidence of fraudulent conduct in touch with the HHS Office of Inspector General. On a deeper level, NAHC has provided guidance to enforcement authorities on areas in which resources might be targeted in their home care efforts.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being replaced with an entirely different form of abuse found in managed care. While in the traditional fee-for-service system incentives exist for overutilization and overcharging. But managed care may create financial incentives to improperly underutilize care. The health care consumer is

harmed doubly in these circumstances; financially, care is prepurchased but not delivered; and healthwise, necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of fraud. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

Recommendations to Combat Fraud and Abuse

During the 104th Congress, NAHC played an active role in helping shape an anti-fraud health care package. Ultimately, these proposals were incorporated into the Health Insurance Portability and Accountability Act, P.L. 104-191, that was passed into law.

Passage of the anti-fraud package marks a good first step in eliminating waste fraud and abuse in our health care system. There are, however, some specific issues within home care that need to be addressed by anti-fraud legislation.

Congress should continue its work in combating waste, fraud and abuse in our nation's health care system by passing a home care specific anti-fraud package that includes:

* **Limiting Agencies' Ability to Subcontract Care.** Medicare certified home health agencies should be allowed to utilize only a limited amount of subcontracted care for the dominant health care service, such as nursing, which they provide.

* **Mandating Freedom of Choice Information.** Hospitals, physicians, and other health care providers, should be required to give patients full information about the availability of Medicare certified home health agencies serving the areas in which the patients reside, and should be prohibited from steering patients to certain agencies.

* **Prohibiting Home Health Agencies from Assisting Physicians in Care Billing.** Home health agencies should be prohibited from providing record keeping and bill preparation services to physicians for their role in home care.

* **Requiring Home Health Care Administrators to Meet Certification and Accreditation Standards.** The last several years have seen a unbridled growth in the number of Medicare certified home health agencies. Home care agency administrators should be required to meet high and rigorous standards for all aspects of running an agency, including issues that affect quality of care.

III. PPS FOR HOME CARE

Congress has before it a unique opportunity to work closely with the home care community to improve the Medicare home care benefit. The Revised Unified PPS plan offered to Congress by the

home care industry and introduced by Representative Nancy Johnson (HR4229) incorporates the best elements of the home care PPS provisions in the Balanced Budget Act (BBA) passed by Congress and HR2530, the Blue Dog Coalition's budget plan introduced in the 104th Congress.

The Revised Unified PPS Plan represents the most advanced thinking that's been done in developing a PPS plan. It also represents a substantial improvement over the current Medicare cost-based reimbursement system.

Let me be very direct regarding the context in which we are offering this PPS proposal. In 1995, Congress proposed sizable savings from the Medicare program, a portion of which was to come from home care. Since the industry found copayments and bundling unacceptable, Congress challenged us to develop a more acceptable way of achieving the required savings. This PPS proposal was developed as an alternative to home care copays, bundling, and other onerous ideas, and that is the context in which we are offering it today.

Our goal was to develop a PPS plan that 1) the home care industry could support, 2) would use the best that both the Republican (BBA) and Democratic (HR2530) plans had to offer, 3) would address concerns raised about the PPS plans in both the BBA and HR2530, 4) would accommodate deficit reduction requirements, 5) would substitute for home care copays and bundling, and 6) would address HCFA's concerns about feasibility of implementation on a timely basis.

Advantages of PPS

PPS offers numerous advantages to the Medicare program over the current cost-based reimbursement methodology. Under current law, home health agencies are reimbursed for the allowable costs which they incur in caring for Medicare patients up to a per visit cap. Cost reimbursement, however, has been criticized because it is complex and costly to administer, because the amounts that are paid are subject to disallowance and recoupment long after the services have been rendered and because it offers no incentives for provider efficiency.

PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid these problems because payment rates would be established in advance.

PPS, by providing financial incentives for home care agencies to reduce both visit and total case costs, will achieve Medicare savings without restricting beneficiary access to high quality home care services. PPS properly places the burden to be efficient in the provision of care on providers and not beneficiaries. Alternatives to PPS, like copayments and bundling, create barriers to high quality home care services by increasing a beneficiary's out-of-pocket expenses and restricting access to post-acute care services.

Revised Unified PPS Plan

The Revised Unified PPS Plan that we are testifying in support of today is a modification of the original unified plan submitted to Congress in 1995.

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. Our goal was to develop an episodic system which would:

- be developed cooperatively by HHS, the industry, and Congress,
- be acceptable to the industry,
- include extended care,
- be submitted to Congress one year in advance of implementation, and within four years of enactment of legislation,
- be implemented only after Congressional approval,
- include adjustments for new requirements (such as OSHA) or changes in technology or care practices,
- be based on a case-mix adjuster that reflects the differences in cost for different types of patients,
- prevent the imposition of home care copays, bundling, or other benefit limits,
- implement a per-episode PPS as soon as possible, and
- do as little harm as possible to home care patients and providers in implementing an untested system.

This plan, which represents years of work and refinement by the home care industry, calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case-mix adjuster and would require the development, within five years, of a per-episode PPS with a case-mix adjuster that adequately distinguishes the cost of providing services to various types of patients.

Phase 1 of the Plan would implement a prospectively-set standard per-visit payment with an annual aggregate per-patient limit that applies to all visits. Phase 2 would put in place prospectively set standard per-visit payments with an annual aggregate episode limit for days 1 - 120 and an annual aggregate per patient limit for visits after 120 days. Phase 3 puts in place a per-episode PPS.

This PPS plan would give home care providers incentives to reduce costs and increase efficiency through a provision in which they would be allowed to keep a portion of the difference between the total per visit payments and the agency's annual aggregate cap. This provision differs from the way PPS for hospitals was implemented, in which hospitals are allowed to retain the entire difference between the DRG payment rate and the cost of care. Under the revised unified PPS proposal, home care providers would be allowed to retain 50 percent of the difference, up to a cap, with the balance of the savings used for the exceptions process.

Scoring

NAHC has been working with the accounting firm of Price Waterhouse in reviewing the potential cost savings available through this proposal. We believe it to represent savings roughly equivalent to the

savings offered under the Administration's PPS proposal and have built into the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about certain assumptions the Congressional Budget Office has employed in scoring PPS proposals for home care. In assessing the prospective payment proposal included in HR2491, CBO imposed a 66 2/3 % offset that had the effect of dramatically reducing potential savings the proposal could have achieved. This offset reflects CBO's assumptions of behavioral changes on the part of home health care providers in response to this proposal, as well as their assumption of the proposal's effectiveness.

CBO used this two-thirds offset to calculate net savings for the home health prospective payment provision, meaning that the sum of gross savings for each provision of the proposal was reduced by two-thirds. Under this offset, a proposal scored at $14.2 billion in savings over seven years, as was the PPS proposal in the BBA, actually would reduce Medicare home health expenditures by $42.6 billion over seven years, or three times the scored amount.

Never before, to our knowledge, has CBO employed such a dramatically high assumption of gaming. An offset of this magnitude is entirely unjustified and makes it much more difficult for home care to present a proposal offering necessary savings that does not inflict great hidden harm to home care beneficiaries.

History of PPS

NAHC has long supported the development of a prospective payment system for home care. NAHC championed the initial PPS demonstration legislation that Congress passed in 1983 as part of the Orphan Drug Act (P.L. 97-414). In that legislation, Congress required the Medicare program to test alternative reimbursement methodologies to determine the most cost effective and efficient way of providing care, including fee schedules, prospective payment, and capitation payments.

Following the passage of this legislation, the industry, through the National Association for Home Care, created its first Prospective Payment Task Force. When the demonstrations authorized under that legislation were held up in 1985 by the Office of Management and Budget, NAHC stepped in and partially funded the Georgetown University study on patient classification.

The U.S. Department of Health and Human Services (DHHS) did not undertake any serious effort to follow through with the study required in the 1983 legislation. Accordingly, the industry sought a stronger mandate from Congress.

With the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Congress required that DHHS design a prospective payment demonstration in a manner that would enable the Secretary to evaluate the effects of various methods of prospective payments (including payments on a per visit, per case, and per episode basis) on program expenditures, as well as beneficiaries' access to care. An interim report was required by Congress within one year after enactment of the legislation. A final report was due four years after enactment. The demonstration was set to begin no later than July 1, 1988.

The Health Care Financing Administration (HCFA) was unable to move the demonstration project forward on a timely basis and sought a delay from Congress. As part of the Medicare Catastrophic Protection Act of 1988, OBRA-87 was amended to modify the effective date from July 1, 1988, to April 1, 1989.

After nearly three years with limited effort by DHHS, Congress, at the request of the home health industry, once again intervened in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Congress directed HCFA to research and report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. DHHS was required to submit a report to Congress that included a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission was to analyze the DHHS proposal and report to Congress by March 1, 1994.

In developing this proposal, DHHS was required to:

(1) provide for appropriate limits on home care expenditures;

(2) account for changes in patient case-mix, severity of illness, volume of cases, and the development of new technologies and standards of medical practice;

(3) consider the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;

(4) address the varying wage-related costs among agencies; and

(5) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Ultimately, HCFA initiated a two phase demonstration project to study prospective payment for home health services. In Phase 1, HCFA experimented with a per visit prospective payment methodology. That project, which concluded in 1994, found limited effect on the behavioral actions of home health agencies and expenditure through the use of a per visit method of reimbursement.

Phase 2 of the demonstration project was initiated in March, 1995. Phase 2 is intended to study the behavioral reaction to a per episode based prospective payment system using a case-mix adjustor that classifies patients into one of eighteen categories. As the result of the weaknesses of the case-mix adjustor, explaining only 9.7 % of variation in costs for various types of patients, HCFA limited the focus of the demonstration project to analyzing behavioral changes for participant home health agencies. It is expected that a final report will be issued on Phase 2 of the demonstration project in either 1999 or 2000.

We would like to reiterate that the industry's Revised Unified PPS Proposal, while an improvement over the current cost-based reimbursement system, is being offered solely in the context of deficit reduction as an alternative to other home care savings proposals.

Some alternatives, including shifting some home care from Medicare Part A to Part B, placing copayments on Medicare home health visits, and bundling home care payments into hospital DRGs or other provider payments, would have serious detrimental effects on the nearly 4 million Americans who rely on quality home health care. Moreover, these proposals could severely limit access to home care, limiting health care choices for our Nation's elderly and disabled to more costly institutions.

We were extremely gratified that in the BBA, the Committee abandoned home health copayments and bundling in favor of a prospective payment system (PPS) as a way to ensure the efficient delivery of home care services.

IV. PRESIDENT'S FY98 BUDGET PROPOSAL

The provisions included in the February 11, 1997 draft of the Administration's FY98 budget package would have a dramatic impact upon the delivery of home health care under Medicare. Home care would be subject to a level of cuts which is disproportionate to its share of the Medicare program. Home health comprises 9.6% of total Medicare outlays, but would sustain 13 % of the cuts requested by the President. For comparison purposes, skilled nursing facility payments now comprise about 6% of total Medicare outlays, but would sustain 7 % of the cuts, which is much closer to its proportion of program outlays.

Beyond the depth of the home care cuts, NAHC has grave concerns about the overall effect of the Administration's budget on the future of the Medicare home health benefit. While the President's proposal puts forth a plan to implement a prospective payment system (PPS) for home care and takes a first step toward providing much-needed respite for informal caregivers of Medicare Alzheimer's victims, draft legislative language reveals proposals that would create two separate home care benefits under Part A and Part B of Medicare, impose arbitrary limits on home care and reverse hard-won legal battles which broadened availability of home care to deserving beneficiaries. Additionally, the proposed FY98 budget would grant broad Secretarial authority to deny payment for services which lie outside "norms of care" and to lump post-acute services into a single care payment.

Despite some benefit expansions, the proposed budget translates into very real reductions in access to home care services for needy Medicare beneficiaries.

Transferring Some Home Health Coverage From Part A to Part B of Medicare

Under the President's proposal, Part A would cover home health services only when both of the following conditions are met: (1) home health services are furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than three consecutive days before discharge, or during a covered post-hospital extended

care stay, and (2) the home health services are initiated for such individual within 30 days after discharge from the hospital, rural primary care hospital, or extended care facility.

All other home health care services -- including services not following a hospitalization and services beyond 100 visits -- would be covered under Part B.

The additional home care costs transferred into Part B would not be used in calculating the Part B premium, which traditionally covers 25% of Part B program costs. Individuals who have Part A coverage only would continue to have all their home care services covered by Part A until 19 months after the date of enactment.

This proposal would do little to address the underlying insolvency issues facing the Part A trust fund. We are deeply concerned that this proposed shift will result in increased tax burdens on middle income families and increased costs to Medicare beneficiaries, and may deny needed home care services to millions of seniors and disabled individuals.

This shift would transfer up to $82 billion in costs directly onto taxpayers. The size of the increased burden on taxpayers resulting from this transfer would continue to rise over the years.

If Medicare beneficiaries were required to contribute to the costs of home care transferred to Part B, premiums have been estimated to increase by nearly 20 percent -- $8.50 per month in 1998, rising to $11 .OO per month by 2002. The Part B monthly premium is already $43.80.

This transfer may also make the home care benefit more susceptible to beneficiary copays and deductibles. As a result, Medicare home health beneficiaries could be subjected to additional coverage restrictions that would further reduce the benefit. This proposal would decrease cost-effective medical benefits to millions of Americans at a time when the need for home care services is growing.

We are additionally concerned that 2.1 million elderly and disabled Medicare beneficiaries who are covered by Part A, but not by Part B, may lose access to much of the Medicare home care benefit under the President's proposal. Beginning 19 months after enactment, the benefit for these individuals would be limited to only 100 visits and only if the care began immediately following a hospital stay of at least three days or discharge from a covered extended care facility. To the extent that these individuals are either already Medicaid eligible,- or would spend down to Medicaid due to increased health care costs, this provision would result in an increased burden on State Medicaid programs.

NAHC proposes, instead, fundamentally improving the way Medicare pays for home care services by enacting a prospective payment system (PPS) for home care.

PPS For Home Care

The Administration's PPS proposal included in the FY98 budget submission falls short of the industry's expectations in a number of ways.

The interim payment proposal essentially continues the present cost-based reimbursement system, while eliminating any savings sharing that gives providers incentives to reduce costs and increase efficiency. Both the Administration's previous plan, as well as HR 2491 (the Congressionally passed plan) and HR 2530 (the Democratic alternative) contained such incentives for providers. With the retention of cost reimbursement and the elimination of the savings sharing provisions, this plan contains little by way of incentives for providers to participate in creating more efficient operations.

The interim system would also delay the implementation of blended limits for three months. Totally agency-specific limits tend to maintain previous behaviors, both good and bad. This delay would penalize the most efficient providers.

The Administration's plan also calls for the collection of data to develop a reliable case mix adjuster. While clearly necessary, this provision would result in substantial additional costs to agencies. The cost of this new data gathering requirement should be fully reflected in reimbursement rates under this system.

The Administration's PPS plan has serious flaws, as well. Under this plan, the prospective payment system is to be devised by the Secretary without Congressional oversight or participation by industry or consumer groups. The Administration would also reduce home health cost limits and per-beneficiary limits by 15 %, prior to implementation of PPS. This reduction is onerous and unnecessary under PPS.

Interim Payment for Home Health Services

This provision delays updates in the Medicare cost limits from July 1, 1997, to October 1, 1997. As of October 1, 1997, the cost limits would be calculated on the basis of 105% of the median of the labor-related and nonlabor per-visit cost for freestanding home health agencies. Currently, cost limits are calculated on the basis of 112% of the mean. The standard of 105% of median is the effective equivalent of approximately 97% of the mean.

A reduction of the cost limits to 105 % of the median is estimated to affect the limits by approximately $10.00 per visit for skilled services and nearly $5.00 per visit for home health aide services. This amendment combined with the disregard of two years of cost increases under the section that maintains the savings from the freeze (discussed below), would reduce the cost limits by approximately 17 % .

The delay in cost limit updates could provide a benefit to providers of services having cost reporting periods beginning between July 1 and September 30. These providers would maintain the same higher level of cost limits than would be calculated under the revision for a period of two years, while providers of services with fiscal years beginning on or after October 1 would be subject to a precipitous drop in allowable reimbursement.

The savings resulting from the freeze and the interim payment system would be unnecessary if the industry's Revised Unified Plan for Prospective Payment were adopted by the Congress. While the

industry's plan would reduce per-visit payment, it gives providers a more important incentive to reduce overall case costs by restraining the growth in the utilization of services per patient.

PPS would achieve reasonable payment reform and associated budget savings without dramatic reductions in the unit of payment. With the current high degree of federal regulation of home health services, it is difficult and sometimes impossible for a home health agency to initiate large cost reductions with little or no notice. The proposed cost limit reductions ultimately carry the risk that quality of care and access to services may be jeopardized.

Maintaining Savings Resulting From Temporary Freeze on Payment Increases for Home Health Services

This provision in the President's package requires the Secretary to disregard increases in the cost of providing home health care which occurred between July 1, 1994, and July 1, 1996, in updating the home health cost limits after September 30, 1997. The purpose of this provision is to recapture the savings which the program would have incurred if the two-year freeze, which was lifted on July 1, 1996, had been continued. The proposal also limits the Secretary's authority to consider cost changes during the two year period when determining whether a home health agency is entitled to an exemption or exception from the cost limits.

This provision would significantly reduce the current Medicare cost limits. Those limits, implemented with cost report years beginning July 1, 1996, represented the first increase in the limits for home health agencies since July 1, 1993. The reduction in the cost limits through this provision would approximate $7.00 per visit or 7% of the limits. As a result, a significant percentage of home health agencies would provide services at costs above the limit, receiving less reimbursement than me cost of providing the care.

As mentioned earlier, the impact of this provision is magnified when combined with other sections in the President's budget proposal, including the section on interim payment methodology, which further reduce the cost limits for all home health agencies.

Clarification of Part-time or Intermittent Nursing Care

This amendment modifies two provisions of Medicare law which affect the eligibility of beneficiaries for home health services coverage and the level of coverage available. With respect to the test to qualify for home health services coverage, current law requires that the Medicare beneficiary demonstrate a need for skilled nursing care on an intermittent basis or physical or speech therapy.

The provision would restrict Medicare home health eligibility and coverage beyond that available under current law. The existing interpretation of "part-time or intermittent" is the result of a 1988 class action lawsuit which invalidated restrictions on daily, part-tune care.

The President's proposal defines "intermittent" as skilled nursing care that is either provided or needed on fewer than seven (7) days each week or less than eight (8) hours of each day of skilled

nursing and home health services combined for periods of twenty-one (21) days or less with certain exceptions. At present, there is no definition of "intermittent" contained within existing statute or regulations.

With respect to the level of coverage available for a qualified Medicare beneficiary, current law limits coverage of skilled nursing care and home health aide services to care which is "part-time or intermittent. " This amendment proposes to define "part-time or intermittent" services as a combination of skilled nursing and home health aide services furnished less than eight (8) hours each day and thirty-five (35) or fewer hours per week. There is no existing statutory or regulatory definition of this term.

The proposed definition of "part-time or intermittent services" eliminates an important protection which allows for coverage beyond thirty-five (35) hours per week under exceptional circumstances when the need for the additional care is finite and predictable. This component of the definition allows for short term extended hour coverage for individuals such as those awaiting placement in a skilled nursing facility where no bed was available and those patients with a short term acute episode of care which could be reasonably provided at home, avoiding institutional placement in a hospital or nursing facility.

The proposed definition of "intermittent" used to qualify a Medicare patient for home health services also adds new restrictions. While existing law requires the patient demonstrate a need for intermittent skilled nursing care, the proposed definition of "intermittent" combines skilled nursing and other home health services in determining whether the "intermittent" skilled nursing care requirement has been met. This would exclude eligibility for some patients who currently qualify for Medicare home health services coverage.

For example, an individual that receives daily home health aide services from unpaid caregivers, such as family members, while receiving Medicare covered weekly skilled nursing care would be entirely disqualified from Medicare coverage. Even if this definition were limited to the combination of skilled nursing and other home health services provided by a home health agency, currently eligible Medicare beneficiaries would be denied coverage.

To amend the Medicare act as proposed would not result in a clarification of these terms. Instead, it would result in a reduction in benefits to Medicare beneficiaries.

Definition of Homebound

This amendment establishes new criteria for determining whether an individual's absences from the home demonstrate that the Medicare beneficiary fails to meet the "confined to home" standard. Specifically, the proposal requires that an individual demonstrate the existence of a condition that restricts the ability to leave the home for more than an average of 10 to 16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home.

The proposal further defines existing terms of "infrequent" to mean an average of five or fewer absences per calendar month and "short duration" to mean absences of three or fewer hours on average per absence. Current law allows for nomnedical absences which are infrequent or of short duration. Medically related absences for treatment that cannot be furnished in the home do not affect an individual's homebound status.

This proposal would add to the confusion surrounding application of the homebound criteria. Under the proposal, several plausible interpretations may be possible. For example, while the existing law allows for absences which are either infrequent or of short duration, the proposal referencing absences averaging 10 to 16 hours per month may be interpreted to combine these two limitations. At the same time, the 10 to 16 hour reference may be interpreted in a manner which indicates that the restrictions for leaving the home begin only after that number of hours since the word "restricts" is not the equivalent of "prevents. "

Home care agencies and patients are likely to have great difficulty in dealing with the allowance for medical absences in demonstrating that the treatment "cannot be furnished in the home. " Currently, for example, most medically related treatments can be provided in the home. A home visit by a treating physician can often adequately meet a patients needs. However, physician services are not generally accessible in me home.

Many current Medicare beneficiaries, especially disabled patients, may be disqualified from Medicare home health services coverage under this provision. In addition, rather than adding clarity to a confusing area, it only adds to the difficulty in interpretation and application through the addition of new terms subject to dispute.

Individuals that attend adult day care, at no expense to the Medicare program, through the use of specialized transportation should not be disqualified because absences are more frequent than five per calendar month or three hours per absence. These individuals generally cannot receive the necessary health care services outside the home and are truly homebound in the absence in the specialized transportation. Likewise, disabled individuals who are bedbound without the assistance of home health staff should not be disqualified where specialized equipment allow these individuals to leave the home for education, employment, or other purposes. Disqualifying these individuals due to their absences eliminates the availability of essential services which create the opportunity for absences. Many disabled individuals are bedbound unless home health services are provided.

Normative Standards for Home Health Claims Denials

This provision provides authority to the Secretary to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines as the Secretary shall by regulation establish. " This provision allows the Medicare program to utilize norms of care for eliminating coverage to individuals.

The Medicare program's practice of using norms of care was outlawed under a settlement agreement in the national class action Duggan v. Bowen in 1989. Under that settlement, the Medicare program

is required to render individualized claim determinations which respect a particular Medicare beneficiary's illness, condition, and need for treatment. At that time, it was recognized by the Medicare program that the determination as to the level of care which was reasonable and necessary could only be rendered through an individualized review of that patient's circumstances.

This provision should be rejected. The federal government should not attempt to micro manage how much and what types of home care services each patient can receive. PPS for home care would provide prudent payment levels while allowing home health care providers (could) to determine how best and most efficiently to meet patients' needs. A similar approach is used with Medicare hospital services under which a flat payment is made to a facility based upon a patient's diagnosis regardless of whether the patient receives care less than or in excess of the norms. The hospital payment provision, however, provides for an outlier payment to recognize that certain patients reasonably require care beyond normative standards.

Further, the Secretary cannot reasonably and accurately establish normative guidelines for home care. Currently, the Medicare program is developing a case mix adjuster for use in a future PPS. However, that case mix adjuster, while categorizing patients, is expected to allow for flexibility in the provision of services to patients within the respective categories.

The use of norms implies an average amount of care for patients within set criteria. Averages cannot be used to deny coverage to individuals since the averages are made up of a range of care needs of specific patients. This proposal will guarantee that many individuals who need home health services would be denied Medicare coverage.

The implementation of this provision will also lead to an endless series of disputes, including litigation, as to the accuracy and objectivity of the calculated norm of care for the particular category of patient. In the end, this provision will be costly to administer, creating harm to Medicare beneficiaries, leading to increased health care costs for underserved patients, and restricting coverage to individuals currently entitled under Medicare law.

Development and Implementation of Integrated Payment System for Post Acute Services

This provision authorizes the Secretary to establish an integrated payment system for post acute services furnished by skilled nursing facilities, home health agencies, rehabilitation hospitals, long term care hospitals or such other entities as the Secretary deems appropriate. The payment system may include a single prospective pay rate for all services or a limit on the amounts payable to individual providers or to a single entity.

In establishing the payment system, the Secretary must consider equitable payments across provider types, case mix adjustments, geographic variation, and outlier payments. The Secretary must establish the system to be budget neutral. The system must include quality assurance and monitor. Finally, the Secretary is authorized to require providers of services to supply the necessary data and other information necessary for implementation, including the development of a standardized core patient assessment instrument.

The authority of the Secretary to implement an integrated payment system for post acute services does not apply to payments for services furnished before 2002.

NAHC opposes combining, or bundling, home care payments with payments to other providers. Congress should, instead, enact separate prospective payment systems for home care and other post-acute care providers.

Congress should also rebase the hospital DRGs to reflect shorter lengths of stay that have occurred under the hospital PPS.

Nearly half (41%) of all home care patients are now able to receive care and treatment at home from the onset of their illness, avoiding hospitalizations altogether. According to the Prospective Payment Assessment Commission's (ProPAC) June 1996 report to Congress, patients in other post-acute settings were usually discharged from acute care hospitals, but only 59% of all home health episodes were preceded by a Medicare-covered hospital stay.

Bundling would vastly increase Medicare's administrative complexity and the cost of providing home care services by requiring multiple payment systems for home care -- one for post-acute patients and one for other home care patients.

User Fees

The Administration would allow States to impose user fees on providers for initial surveys needed for participation in the Medicare program. NAHC opposes user fees and recommends that Congress ensure sufficient funds to cover the costs for survey and certification activities without imposing additional fees on providers.

For the past several years, HCFA's funding for survey and certification activities has been insufficient to complete the level of reviews mandated by Congress. As a result, many state survey agencies were unable to conduct initial surveys of new providers in a timely manner. Providers in these states, therefore, are experiencing long delays in receiving Medicare certification.

The fiscal year 1996 budget (P. L. 104-134) contained a provision designed to provide HCFA the budget flexibility to begin to alleviate the backlog of initial certifications. The legislation increased the time between home health recertifications from once every 12 months to once every 36 months and expanded HCFA's authority to deem agencies as certified if the agencies are accredited by certain private accrediting bodies. In addition, Congress appropriated an additional $10 million over FY96 levels for survey and certification activities in FY97.

Despite these legislative efforts, backlogs for initial surveys in some states still exist. The Administration's proposal would allow states to impose user fees on providers who wish to pay for their initial surveys. In addition, the President's budget reduces the direct appropriation request for survey and certification by $10 million. The Administration estimates that this $10 million reduction will be made up from user fees, thereby keeping the funding for survey and certification activities at

FY 97 levels.

User fees are a tax on new providers for participating in the Medicare program. Asking health care providers to provide quality care while at the same time asking them to shoulder both government costs and their own expenses related to the Medicare program is unfair. Moreover, while the proposal imposes user fees only on initial surveys, some existing providers may also be subject to this "tax." For example, home health agencies who wish to open a hospice would be subject to the fee for the hospice's initial survey. In addition, HCFA's recent reclassification of some home health branch offices as subunits would also require initial surveys be conducted for those reclassified facilities.

Fraud and Abuse

The President's budget proposal calls for the repeal of advisory opinions, the exception to anti-kickback penalties for risk-sharing arrangements; and the clarification concerning levels of knowledge required for imposition of civil monetary penalties.

NAHC opposes repeal of these important provider guidance provisions contained in the Health Insurance Portability and Accountability Act (P.L. 104-191).

The Health Insurance Portability and Affordability Act of 1996 put in place a broad based anti-fraud package that balances increased enforcement tools with opportunities for provider guidance. The fraud and abuse legislation established a criminal health fraud statute and increased civil monetary penalties. At the same time, the legislation clarified existing law, created a safe harbor exception for certain risk-sharing arrangements and allowed providers to request advisory opinions from the Department of Health and Human Services (HHS).

The health insurance reform law reflected an effort to balance increased enforcement tools with greater opportunities for guidance and clarification of areas that have previously led to confusion and unintended consequences for providers. Provisions such as the establishment of advisory opinions will assist home care and hospice providers in ensuring that they remain in compliance with health care statutes and regulations. Without these provisions, new criminal sanctions and increased civil monetary penalties may be imposed on home health and hospice providers without adequate opportunities for guidance or clarification of existing law.

Site of Service

The intent of this section in the President's proposal is to ensure that Medicare payments for home care more closely reflect the costs of care in the place where the care is given, the patient's home, rather than the site of the home health agency office.

This section would address this issue in two ways: It may require home health agencies to submit each claim to the fiscal intermediary (FI) that covers the patient's home, rather than submitting all claims to the FI that covers the agency office location, or to require information on the patient's

location to be included in the claim. It may also require that the labor costs associated with the area in which each patient receives home care, rather than the agency office, be used in calculating Medicare payment limits for home care services.

NAHC supports this section, with two significant changes.

First, the section should be rewritten to clarify its intent and to amend Section 1815, rather than Section 1891, of the Social Security Act.

Section 1891 of the Social Security Act sets out requirements to assure home health quality, such as patient rights, training and competency testing of home health aides, and quality surveys and sanctions for home health agencies found to be out of compliance with the quality measures of Section 1891.

The President's proposal would require quality surveyors to begin examining claims forms to find that they match with the correct FI for each patient's area. Quality surveyors are already sorely overworked and underfunded. This non-quality specific requirement would detract from their ability to devote their efforts to ensuring high quality standards in all home health agencies.

This section should be moved to Section 18 15 of the Social Security Act, which sets out requirements that providers must meet in order to receive payments under the Medicare program.

Second, home care payments should reflect the labor costs for activities performed both in the patient's location and in the home office area. The Administration's proposal would only recognize the varying labor costs that occur specific to the site of care. Billings, clerk functions, and other activities that are carried out in the agency office should reflect the costs of labor in the office location.

Respite

The President's budget proposal would establish a new respite benefit for the families of Medicare beneficiaries with Alzheimer's disease or other irreversible dementias, beginning in FY98. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the Secretary of HHS.

Payments would be made at a rate of $7.50 per hour for 1998 and at a rate to be determined by the Secretary in subsequent years. Total payment to the agency or organization furnishing respite services could not exceed 110 percent of the hourly respite allowance times the number of hours of respite for which the agency authorizes payment.

Beneficiaries eligible for this benefit must be severely impaired due to irreversible dementia and need assistance in at least one of five activities of daily living (bathing, dressing, transferring, toileting and eating) or in at least one out of four instrumental activities of daily living (meal preparation, medication management, money management, and telephoning), or needs constant supervisionbecause of a behavioral problem.

Families would be allowed to designate a respite services caregiver through a home health agency or other organization designated by the Secretary. The patient could not be charged more than $2.00 in excess of the the hourly rates established by the legislation.

Respite aides may be nurse aides, home health aides, or other individuals licensed by the State or recognized by the Secretary as having the skills necessary to provide such services.

NAHC is pleased that the Administration has proposed a modest beginning in addressing this unmet need. Nearly three-quarters of non-institutionalized disabled elderly persons rely solely on care by friends and family; only 5% receive all of their care from paid sources.

While the respite provision is a step in the right direction, it provides for too few hours and the rates of reimbursement are inadequately low. Payment rates should reflect variation in costs by geographic region and should be adequate to both attract qualified respite aides and pay for their training and supervision. The legislation should also mandate that the Secretary develop competency standards for respite aides.

The availability of respite care can mean the difference between continuation of in-home care and institutionalization. Experience with the implementation of even a small scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria and quality assurance. This information will be essential to the future development of a more comprehensive benefit.

Ultimately, Congress should include in-home respite care in the Medicare home health benefit. Eligibility should be based on a broader definition of functional and cognitive impairments.

Elimination of Periodic Interim Payments for Home Health Agencies

This proposal eliminates the availability of a longstanding method of payment for home health agencies known as Periodic Interim Payments (PIP), effective with the initiation of a proposed prospective payment system (PPS) on October 1, 1999.

PIP is a system which projects an agency's expected Medicare home health payments and provides biweekly reimbursement to the agency based upon that projection. Under PIP, adjustments for underpayments and overpayments are made throughout the fiscal year in order to achieve reimbursement consistent with total amount owed by the end of the fiscal year.

Periodic Interim Payments have been essential for many home health agencies in order to maintain an appropriate cash flow to meet the labor-intensive cost of delivering home health services. Unlike many other health care providers, such as hospitals and nursing facilities, home health agencies do not have ready access to capital or credit due to a lack of profits through cost reimbursement and limited capital equity. PIP has helped providers avoid interest costs and revenue shortfalls which could jeopardize the continued delivery of services to patients.

The industry has expressed a willingness to accept the elimination of PIP corresponding with the implementation of the industry's PPS plan. The Administration's proposal however, while eliminating PIP at the implementation of PPS, does not provide the type of interim PPS system proposed by the industry which would allow for home health agencies to build capital pending the transition to PPS. NAHC recommends that PIP, in this case, be eliminated twelve months after the implementation of episodic PPS.

Payment Under Part B

This section amends Section 1833(a)(2) of the Social Security Act, conforming payments for Medicare Part B home health services to the amended cost limit provision and interim payment methodology set out in the President's package. In addition, it has the effect of eliminating the lower of cost or charges principle from the determination of rates of payment. Currently, Medicare limits reimbursement to home health agencies based on the lower of its costs or charges. This proposal will continue an exemption from the lower cost or charges principle for certain public providers that offer services at a nominal charge.

While the provision appropriately modifies Part B payment structures to conform with the overall payment reform measures affecting home health services under Medicare, it may have inadvertently eliminated application of the lower of cost or charges principle. The NAHC supports the elimination of the lower cost or charges rule (LCC). However here, the proposed action eliminates LCC only for Part B and not for Part A.

V. OTHER ISSUES OF IMPORTANCE TO HOME CARE

Waiver of Liability

Also included in the BBA and closely linked to enactment of PPS was a provision to extend the presumptive status of the waiver of liability for home care, a provision of great importance to NAHC.

In 1972 the Health Care Financing Administration created a presumptive waiver of liability status for Medicare providers. Under the presumptive waiver, providers were presumed to have acted in good faith and were paid for services to a Medicare patient if their low error rate demonstrated a reasonable knowledge of coverage standards in their submission of bills. The presumptive waiver was later incorporated into legislation which after several extensions expired for home care and hospice on December 31, 1995.

The BBA would have extended the presumptive waiver for home care until October 1, 1996, when the Act provided that a prospective payment system would be established for home care. When the Act was vetoed, the presumptive status of the waiver expired.

To make matters worse, HCFA has imposed a system which presumes fraud by assuming providers

knew their claims would not be covered, forcing providers to appeal each claim. Reconsideration of claims costs the federal government approximately $400 per claim, and costs providers in the range of $150 for each claim, just to reach the point of requesting waiver protection. If the dispute moves to the Administrative Law Judge level, the federal government and the provider each incur likely costs of $1,000 per claim reviewed.

In order for a home care agency to be compensated under the waiver presumption, its overall denial of claims rate had to be less than 2.5 % of the Medicare services provided. Any agency that exceeded this limit was not reimbursed under the presumptive waiver. This requirement forced agencies to use due diligence in determining eligibility and coverage.

Given the vague application of constantly changing regulations, guidelines, and directives, it is difficult enough for home health agencies to be 97.5 % correct in their determinations of eligibility. The high number of claims denials that are reversed (25% at reconsideration stage and 70% at the Administrative Law Judge level) shows that coverage decisions are not as clear cut as HCFA asserts. At a time when sicker patients are admitted to home care following earlier hospital discharges, coverage questions are more complex, and the buffer zone of the waiver presumption is particularly important.

Congress enacted the presumptive waiver to encourage home health agencies to provide services to Medicare patients, and to save on the considerable administrative time and expense of handling appeals in cases where agencies are delivering services in the good faith belief that the services are covered by Medicare. In the absence of the waiver presumption, agencies will have no recourse but to reject clients if there are any doubts about coverage. The waiver presumption for home health agencies and hospices should be permanently reinstated and made retroactive to January 1, 1996.

Copays

We are gratified that the President's FY98 budget proposal does not include the imposition of copayments on Medicare home health services. Imposition of a home health copayment would create a new "sick" tax on the most frail and vulnerable elderly and disabled Americans -- those who could least likely afford it. Moreover, the policy is "penny wise and pound foolish" and may end up costing the hledicare program more since patients who cannot afford the copayment may defer necessary services, resulting in subsequent nursing home placements, hospitalization or care from other more costly institutions.

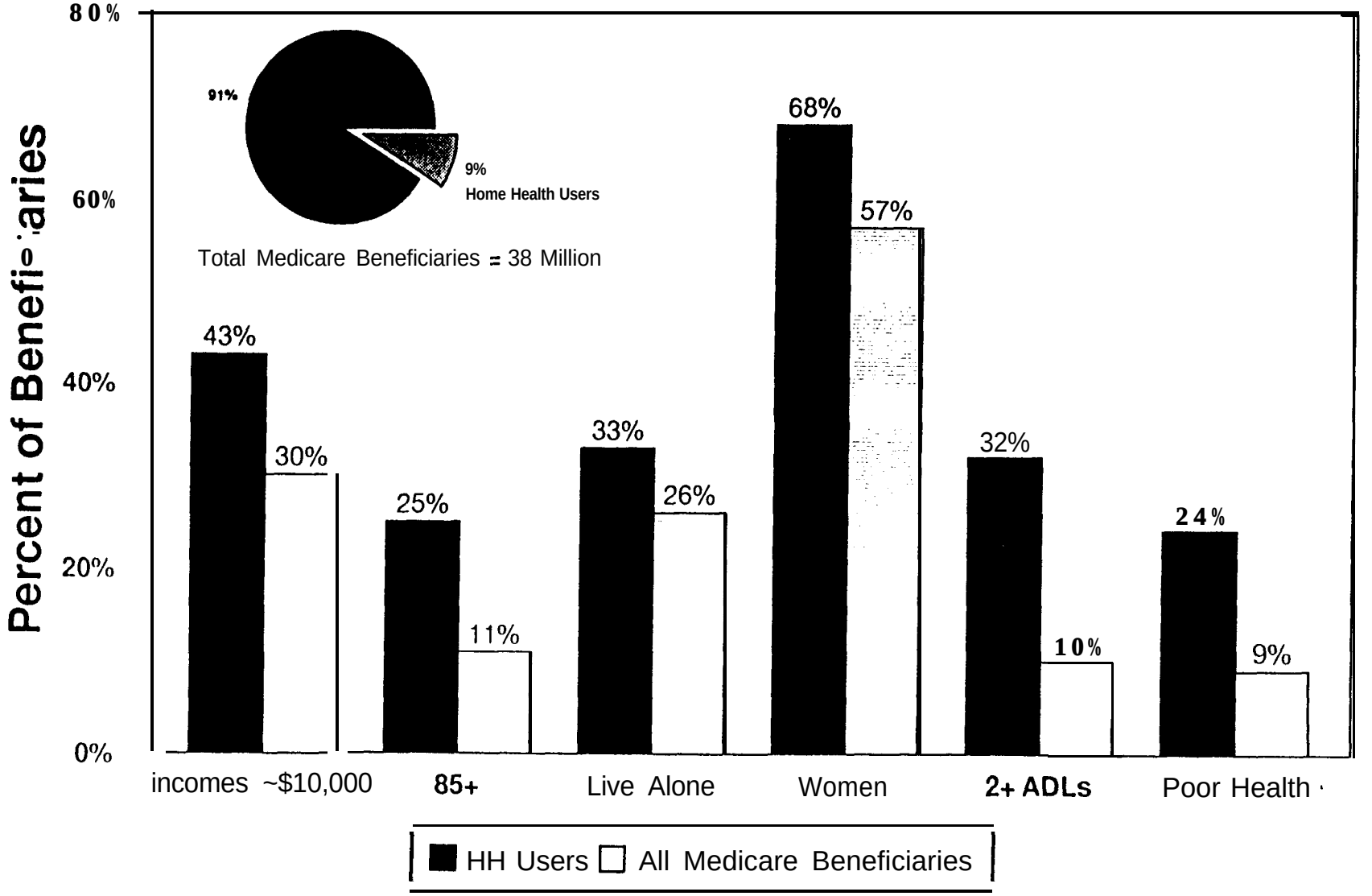
Medicare home health copayments do not take into account the in-kind contributions made by Medicare home care patients toward the cost of their care. When Medicare pays for the care of an individual in a nursing home or hospital, it also pays its share of the cost of the building, maintenance, overhead, food, heat, and other significant costs, none of which Medicare incurs with home care. In addition, home care patients, families, and friends make significant contributions to care through "sweat equity. " Individuals who receive no Medicare reimbursement provide significant care to Medicare home care patients, as home care nurses train family members and friends to provide care at home.

When the home health benefit was first enacted in 1965, it contained a copayment requirement. This copayment was later dropped because it cost Medicare more to collect in administrative costs than it saved the program. Copayments were a bad idea then, they are a bad idea now.

CONCLUSION

Thank you again, Mr. Chairman, for the opportunity to present our views. Home care has waited for many years to get to this point in the development and consideration of a prospective payment system for home care. You and the Committee have our thanks for bringing the issue to this level of consideration and we look forward to working closely with you in bringing PPS to enactment and on the other important issues facing home care this year.

Characteristics of Medicare Home Health Users



ource: HCFA, 1994 Medicare Current Beneficiary Survey

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, SE
Washington. DC 20003
202/547-7424. 202/547-3540 fax

February 28, 1997

The Honorable William M. Thomas
U.S. House of Representatives
2208 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Thomas:

The undersigned state home care associations urge you to oppose any attempt to shift funding for home health care from Part A to Part B of Medicare.

Home care provides a wide range of vital health care services for 3.5 million elderly and disabled Americans. The Medicare home health benefit allows these individuals to remain in their own homes, often avoiding more costly hospitalizations.

Shifting partial funding for the benefit from Part A to Part B of Medicare would not achieve true savings toward reducing the federal deficit, nor would it address the underlying issues surrounding the impending insolvency of the Hospital Insurance (Part A) Trust Fund.

The A to B shift may also make home care more susceptible to Part B copays, which are extremely regressive, as well as attempts to "bundle" home care payments with hospital DRGs or with other post-acute provider payments. The proposal could also result in tremendous increases in Medicare administrative costs.

We urge your support of maintaining home health care as a Medicare Part A benefit, as well as your support for enactment of a prospective payment system for Medicare home care.

Sincerely,

The Undersigned Members of
The National Association for Home Care Forum of State Associations

Forum of State Associations A to B Letter

Alabama Association of Home Health Agencies
Alaska Home Care Association
Arizona Association for Home Care
Home Care Association of Arkansas
Home Care and Hospice Assn of California
California Assn for Health Services at Home
Home Care Association of Colorado
Connecticut Association for Home Care
Delaware Assn for Home & Community Care
Capital Homecare Association
Associated Home Health Industries of Florida
Georgia Association of Home Health Agencies
Georgia Assn of Community Care Providers
Georgia Staffing and Home Care Association
Hawaii Association for Home Care
Idaho Association of Home Health Agencies
Illinois Home Care Council
Indiana Association for Home Care
Iowa Association for Home Care
Kansas Home Care Association
Kentucky Home Health Association
HomeCare Association of Louisiana
Home Care Alliance of Maine
Maryland Association for Home Care
Home & Health Care Assn of Massachusetts
MA Council for Home Care Aide Services
Michigan Home Health Association
Minnesota HomeCare Association
Mississippi Association for Home Care
Missouri Alliance for Home Care
Montana Association of Home Health Agencies
NE Assn of Home & Community Health Agencies
Home Health Care Association of Nevada
Home Care Association of New Hampshire
Home Health Assembly of New Jersey, Inc.
Home Care Council of New Jersey
Home Health Services & Staffing Assn of NJ
New Mexico Association for Home Care
Home Care Association of New York State
New York State Assn of Health Care Providers
North Carolina Association for Home Care
North Dakota Assn of Home Health Services
Ohio Council for Home Care
Oklahoma Association for Home Care
Oregon Association for Home Care
Pennsylvania Assn of Home Health Agencies
PR Home Health Agencies and Hospice Assn
Rhode Island Partnership for Home Care
Rhode Island Visiting Nurses Network
South Carolina Home Care Association
South Dakota Home Health Association
Tennessee Association for Home Care
Texas Association for Home Care
Utah Association of Home Health Agencies
Vermont Assembly of Home Health Agencies
Virginia Association for Home Care
Home Care Association of Washington
West Virginia Council of Home Health Agencies
Wisconsin Homecare Organization
Home Health Care Alliance of Wyoming

Revised Unified Proposal for a
Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Unified Plan for Prospective Payment System (PPS) for Medicare Home Health Services. It was developed jointly by the National Association for Home Care (NAHC) and the PPS Work Group.

This plan is a modification of the original unified plan submitted to Congress in 1995 as an alternative to Congressional movement to impose copays on Medicare home care services or to bundle home care payments into payments to hospitals. The modifications were made to the original proposal to respond to concerns about implementation feasibility raised by HCFA.

This plan incorporates the best elements of the home are PPS provisions in HR 2491 passed by Congress and HR 2530. It represents months of work and refinement by the home care industry. The plan calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case mix adjuster.

PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety, or increasing out-of-pocket casts.

We invite your careful review of this proposal If you have any questions or would like additional information please feel free to contact any of our organizations at tbc numbers listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202-547-7424

PPS Work Group
Jim **Pyles 202-466-6550**

3-28-96

Home Care's Plan to Implement Prospective Payment for Medicare Home Health Services

I. Home Care's Goal

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality are for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as fusible. PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS an accomplish this goal without jeopardizing beneficiary health and safety.

PPS will be phased in over time, culminating in an episodic prospective payment system plan that should:

- be developed cooperatively by HHS, the industry, and Congress
- be acceptable to the industry
- include extended care
- be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- be approved by Congress
- include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- be based on a case mix adjustor that reflects the differences in cost for different types of patients

II. An Interim PPS Plan

An interim PPS plan incorporating certain elements of the Congressional and Democratic proposals (HR 2491 and HR 2530) should be implemented commencing within 6 months of enactment and continue until it can be converted to a pure episodic prospective payment system (Phase III). The interim PPS plan should be based on the industry's design and set forth in legislative language. The interim plan is implemented in phases to provide HCFA sufficient time to collect necessary data and to develop required processes and procedures. Current coverage criteria for Medicare home health services should be maintained and no coverage shifted to Part B.

III. Time Line for PPS Phase-In

Enact Legis.	Begin Data Collec	Begin Phase I Interim PPS	Begin Phase II Interim PPS	Report to Congress on Episodic PPS	Expected Implementation Phase III Episodic PPS
0	2mo	6mo	24mo –30mo	48mo	60mo

IV. PPS SPECIFICATIONS

A. Data Collection

HCFA is mandated to begin immediately to develop a data base upon which a fair and accurate case mix adjustor can be developed and implemented. The data base must be able to link case mix data with cost (and utilization) data.

The data base must include a sample sufficiently large to support the development of statistically valid estimates of payment rates and limits for the geographic area used (e.g., MSA/nonMSA, national, census region).

The data base must contain at least:

- items for the 18 category Phase II case mix adjustor
- HCFA form 485
- UB–92
- additional data items that may contribute to a more accurate case mix system, developed with industry participation (such as items from OASIS)

Payment rafts and limits shall be adjusted to reflect cost of data collection

Effective date: 60 days after enactment

B. Phase-In of PPS Beginning with the Interim Plan

Phase I

Prospectively set standard per visit payment (as in HR 2491) with an annual aggregate per patient limit that applies to all visits (as in HR 2530)

Effective date: 6 months after enactment

All currently allowable costs related to nonroutine medical supplies will be included in the data base for calculating the per visit rate, per visit limit, and aggregate limits.

Per visit payment

- o standard per visit rate for each discipline calculated (as in HR 2491) as follows:

  the national average amount paid per visit under Medicare to home health agencies for each discipline during the most recent 12 month cost reporting period ending on or before 12-31-94 and updated by the home health market basket index, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located

- 0 amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) an HHA can demonstrate costs above the payment rare, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- 0 the payment rates and limits are calculated initially from the base year costs and cost limits and updated by the home health market basket index to the date of implementation; they are updated annually by the market basket index

- 0 base year for payment rates and cost limits – 1994 (using settled cost reports)

Agency **annual aggregate per patient payment limit**

- **0 base year** for aggregate payment limit – 1995 utilization data for each agency

- 0 the blended annual per patient limit is based on the reasonable cost per unduplicated patient in the base year (1994 cost per visit-updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 75% on agency data & 25% on census region data for 12 months following implementation of Phase I, then 50% agency data & 50% census region data

- 0 the blended annual aggregate per patient limit is equal to the number of unduplicated patients served in the year multiplied by the per patient blended limit

- 0 census region: the 9 census region geographic areas (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, Pacific)

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate *per* **patient** cap and below 125% of the census region cost/utilization experience shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's **aggregate limit** Such payments may not exceed 10% of an **agency's** aggregate Medicare per **visit** payments in a year.

- 0 Phase I in place 18 months (no longer than 24 months)

Phase II

Prospectively set standard per visit payment with an annual aggregate episode **limit** for days **1–120 (as in** HR 2491); and an **annual** aggregate per patient limit **for** visits **after** 120 days

- **continue** per visit payment as in Phase **I**
- **an** episode is 120 days; post 120 day **care** is paid per visit with an **annual** aggregate per patient **blended limit for the post 120 day period that is separate from the 1–120 day annual aggregate episode limit**
- the **HHA** is credited for a new episode limit if there is a period of 45 days **without** Medicare covered home **health** care services following the 120 day episode (if a patient is readmitted before a new episode can be started, the agency is paid per visit subject to **the aggregate** episode limit if within the **first** 120 days, or the **separate** post 120 day aggregate per patient blended limit if after 120 days)
- the 18 category Phase II case mix adjustor is applied to the **first** 120 days, or a more accurate **one** if available
- the per episode limit (as in HR 2491) is equal to the mean number of visits for **each** discipline during the 120 day episode of a case mix **category** in an area during the base year multiplied by the per visit payment rate for each discipline
- the **annual aggregate** episode limit (as in HR 2491) is **equal** to the number of episodes of each **case** mix category during the fiscal year multiplied by **the** per episode limit determined for such case mix category for such fiscal year
- the region for the episode limit – MSA/nonMSA area
- the annual post 120 day per patient blended **limit** is based on the reasonable cost per unduplicated patient receiving care beyond 120 days in the base year (1994 cost per visit-updated, multiplied by 1995 **utilization)** and updated by the home **health** market **basket** index; calculation based 50% on agency data **&** 50% on census region data
- the annual aggregate post 120 day per patient blended limit is **equal** to the number of unduplicated patients **receiving care** beyond 120 days in the year multiplied by the per patient blended limit
- the current ccnification and coverage **guidelines** continue

Sharing Savings

HHAs that **are able** to keep their total payments for the year below their annual aggregate episode and post 120 day per patient caps; and the post 120 day per patient payments below 125% of the census region cost/utilization experience, **shall** receive a payment equal to 50% of the difference **between** the total per visit payments and the agency's aggregau limits. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a **year.**

Phase III (as noted under the goal in section I)

Per Episode **PPS**

- **developed cooperatively by HHS, the industry, and Congress**
- **acceptable to the industry**
- **includes extended care**
- must be submitted to Congress one year in advance of implementation **and within** 4 **years of enactment of legislation**
- **approved by** Congress
- **adjustments** for **new requirements** (such as **OSHA)** or changes **in** technology or are **practices**
- **case mix** adjustor **that reflects** the differences in cost for different types of patients

C. Additional Specifications that Apply to All Phases

1. **Exceptions: The Secretary shall provide for an exemption from, or an exception and** adjustment to, the **methods** for **determining** payment **limits** where extraordinary **circumstances** beyond the home health agency's control including **outliers** and the case mix of such home health agency, create unintended distortions in care requirements not accounted for in the case mix adjustor payment system The Secretary **shall** develop a method for monitoring expenditures for such exceptions. **Methods should** be developed to allow for additional home care expenditures when they **are** found to decrease **total** Medicare expenditures.

2. **Quality:** ***Any*** prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing **quality. The Secretary** will ensure that the **quality** of services remains **high** by implementing a revised **survey** and certification process which emphasizes patient satisfaction and successful outcomes.

   Home health agencies **will** be required to provide covered services to beneficiaries to the **extent** that those services are determined by the beneficiary's physician to be **medically** necessary.

   There **will** be established a means for beneficiary due process to challenge care and coverage determinations first through internal provider grievance procedures, then through **external** PRO review.

   There will be established a mechanism for quality review for instances of **significant variation** in utilization by providers. (this can address both visits and admissions)

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EXPERIENCE
President and CEO of VNA Healm Care, Inc. **(Hartford-Waterbury-Glastonbury,** Connecticut) and its eight affiliated companies, 1 OS&Present Engineered affiliation with Hartford Health Care Corporation, a large hospital system. Previously served as Executive Vice President, 1982-86 and as President and CEO of The Waterbury Visiting Nurses **Association** from 1978 until merger with the Hartford VNA in 1982. Assistant Director, Regional VNA, **North** Haven, CT, 1976-78. Assistant Director of Nursing and **Inservice** Coordinator St. Joseph's Hospital, Philadelphia, PA 1972-74. Former **staff** nursing **positions.** Associate Clinical Professor, School of Nursing, Yale University, **1978-Present;** Clinical **Assistant** Professor, School of Nursing, The University of Texas Health Science Center at San Antonio, **1989-Present.**

EDUCATION AND SPECIAL RECOGNITION
Elected Fellow of the Foundation for Hospice and Home Care, 1992; Creative Thinking Tribute from **Creative** Thinking Association, 1990; Johns Hopkins University Centennial Medal, 1989; Yale Distinguished Alumna Award, Yale School of Nursing, 1986; Member of the Year, National Association for Home Care, 1984; Andrew Veckerelli Prize, Yale University School of Nursing, 1976. Johns Hopkins Hospital School of Nursing, Diploma; University of Pennsylvania, BSN; Yale University School of Nursing, MSN.

PROFESSIONAL ACTIVITIES
National Association For Home We, Government Affairs Committee, 1995 and Chair **1982-86;** Prospective Payment Task Force, 1995 and 1985; Board **Secretary, 1992-94;** Chair 1986-88. Foundation For Hospice And Home Care, Board and Secretary, **1990-Present.** Member, Ad Hoc Committee to Remove Barriers and Promote Integration, Connecticut Hospital Association, 1995. Member Connecticut Public Health and Addiction **Services** Joint Advisory Council and Public Health Advisory Council, **1994-.** VNA Information Systems, Inc. Board, Secretary, 1993-95. Member, Connecticut Award For Excellence Health Advisory Task Force, 1993. Member, National Steering Committee and Advisory Committee for the W.K. Kellogg Project, 1992-l 994. National Advisory Committee, Center For Health Policy Research, Denver Quality Outcome Study, 1989-91. National League For Nursing, Council of Nurse Executives, Executive Committee, 1990. Connecticut Association For Home Care, Secretary **1981-85;** Board of Directors, 1977-81. Leadership Greater Hartford Alumni Association, **1990-Present.** Corporator, Hartford Hospital, 1991 -Present Editorial Advisory Board **Home Healthcare Nurse, 1988-Present.** 1994 presentation to 1994 Congress of Australian Council of Community Nursing Services.

MAJOR ISSUES RELATING TO PRESENT AND FUTURE HOME **HEALTH** CARE AND HOSPICE: **1996-1998**
1. The transformation of home care from cost-based reimbursement for amounts for service delivered, to managed care and prospective reimbursement for value received.
2. Fraud and abuse in home care.
3. Stewardship of the purpose and values of home care in a changing health care environment

NAHC'S ROLE IN ADDRESSING THESE ISSUES
1. NAHC must provide leadership in: refinement and implementation of an episodic prospective payment system; development of a **sound, reliable** case mix adjustor; and education of agencies and their staff. NAHC should also monitor the migration of patient populations, **especially** Medicare eligibles, to managed care and provide legal challenges to reduced access to home care services, if necessary.
2. NAHC must continue to provide leadership and education on ethical and reimbursement issues in home care, to mitigate inadvertent fraud and abuse; and continue to aggressively oppose willful misconduct by home care agencies.
3. NAHC should maintain its high profile of stewardship of the values and purpose of home care for the provision of necessary and appropriate cost-effective care. It should develop positions for assuring that home care assumes its rightful role as a central core of any integrated delivery system or reformed health care system.

SUMMARY OF THE TESTIMONY OF THE NATIONAL ASSOCIATIONFOR HOME CARE BEFORE THE HOUSE COMMERCE SUBCOMMITTEE ON HEALTHANDENWRONMENT
MARCH 5, 1997

The National Association for Home Care (NAHC) greatly appreciates the opportunity to testify before the House Commerce Subcommittee on Health and the Environment on the Medicare home health benefit. As you know, nearly 4 million Medicare beneficiaries will receive home health services in the next year enabling them to stay out of institutions and remain in their homes with their families and loved ones.

NAHC's testimony will explore the recent growth in the home health benefit and the factors underlying such growth. It is NAHC's contention that reductions in the length of hospital stays, coverage clarifications, the cost effectiveness of the benefit, an aging population, technological advances and increased public preference for home care have all contributed to its recent growth. NAHC is concerned, however, that reductions in home care spending will likely result in greater Medicare expenditures for hospital in-patient and emergency care, physician services, and nursing home care.

The testimony also outlines NAHC's concerns about fraud and abuse and efforts by the home health industry to combat fraud. NAHC supported the anti-fraud package that was included as part of the Health Insurance Portability and Accountability Act of 1996 and has worked with federal enforcement authorities in the implementation of the Administration's anti-fraud initiative, Operation Restore Trust. In addition to these provisions, NAHC recommends passage of a home care specific anti-fraud package.

NAHC advocates the implementation of a prospective payment system (PPS) as an alternative to copayments and bundling, as the mechanism to control costs within the Medicare home health benefit. PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid the administrative complexity and the potential for over utilization present in the current cost-based reimbursement system.

The Revised Unified PPS plan, which NAHC and the majority of the home health industry supports, promotes efficiency and preserves access to quality home care services. The plan calls for a three-phase approach to achieving an episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case-mix adjuster and would require the development, within five years, of a per-episode PPS with a case-mix adjuster that adequately distinguishes the cost of providing services to various types of patients.

The testimony also includes a detailed analysis of the Medicare home health provisions contained in the President's budget. We would like to note that the President's budget contains a disproportionate amount of cuts to home care, in relation to its share of the Medicare program (home care comprises 9.6% of total Medicare outlays, but would sustain 13 % of the cuts requested by the Administration). These provisions, if enacted, would dramatically affect access to home care services for needy beneficiaries.

Thank you again for the opportunity to present our views on reforming Medicare to bring more efficiency to the home health benefit. We look forward to working closely with the Committee in bringing PPS to enactment and on other important issues facing home care this year.